EXHIBIT 5

PLAINTIFF PROFILE FORM

This Plaintiff Profile Form ("PPF") must be completed by the plaintiff or the representative of plaintiff's decedent. In completing this PPF, you are under oath and must provide information that is true and complete to the best of your knowledge, information and belief after reasonable inquiry. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect.

In filling out this PPF, please use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent; (2) "**document**" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies, and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

Information provided in this PPF will only be used for purposes related to this litigation and may be disclosed only as permitted by the protective order in this litigation. This PPF is completed pursuant to the Federal Rules of Civil Procedure governing discovery.

1. CASE INFORMATION

Name of Person Completing Form:	Edith		Small
	First	M.I.	Last
If you are completing this PPF in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:			
Your Name:			
	First	M.I.	Last
Your relationship to individual you represent:			

THE REST OF THIS PLAINTIFF PROFILE FORM REQUESTS INFORMATION ABOUT THE PERSON WHO USED JOHNSON'S BABY POWDER AND/OR SHOWER TO SHOWER AND WAS DIAGNOSED WITH OVARIAN CANCER

2. PERSONAL INFORMATION

Name:	Edith		Small		
	First	M.I.	Last		
Maiden/Other Names Used:					
Current or Last Known Address:	1014 Diamond Avenue		Scranton	PA	18508
Date of Birth: Oct 14 1957			Gender:	Male: ☐	Female: ☒
Date of Death (If Applicable): ☒ N/A			Social Security Number: 201-48-4173		
Select Marriage Status: Single	Name of Spouse, if Married at time of filing Complaint:				

3. **TALCUM POWDER-RELATED CLAIM**

a. Have you been diagnosed with one of the following types of cancer? b. If yes, please provide the approximate date of initial diagnosis (if more than one, for each initial diagnosis). c. If you were diagnosed with ovarian cancer, fallopian tube or primary peritoneal cancer, please provide the type. d. If you were diagnosed with ovarian cancer, fallopian tube or primary peritoneal cancer, please provide the stage.

a. Type of Cancer	b. Date of Initial Diagnosis	c. Type of Ovarian, Fallopian tube, or Primary Peritoneal Cancer	d. Stage of Ovarian, Fallopian tube or Primary Peritoneal Cancer
Cervical	Dec 2 1986	Unknown	Unknown

4. **MEDICAL HISTORY:**

a. Have you ever had a tubal ligation? Choose Yes/No: Yes

If yes, date of procedure: 1984 ☐ N/A

b. Have you ever been tested for a genetic mutation or condition? No

Name of Provider who ordered such testing: _____

c. Have you ever been diagnosed with any of the following?

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
BRCA1 or BRCA2 mutation	No		
Endometriosis	No		
Adenomyosis	Unknown		
Irregular vaginal bleeding	Unknown		
Ovarian Cysts	Yes		2005
Polycystic ovaries and/or Polycystic Ovarian Syndrome (PCOS)	No		
Uterine fibroids	Yes		2011
Infertility	No		
Breast cancer	Unknown		
Lynch Syndrome	Unknown		

Condition	Yes/No/Unknown	Name and Address of Diagnosing Provider	Approximate Date of Diagnosis (if applicable)
Other cancer (please specify below):			
	No		
Obesity/overweight	Unknown		
Pelvic Inflammatory Disease (PID)	Yes		?? ?? 1975
Colon Polyps	Unknown		

6. *Other than* those injuries that you believe were caused by your use of body powder, do you currently suffer from any chronic illnesses or disabilities?
Choose Yes/No: _____

If yes, please identify:
The injury, illness, or disability:

_____

Date(s) of diagnosis:_____

FAMILY MEDICAL HISTORY

7. Limiting this question to blood relatives, to the best of your knowledge, please indicate whether your *parents, siblings, children, grandparents, aunts, uncles, or first cousins* have ever suffered from or been treated for any type of cancer (including but not limited to ovarian cancer or breast cancer):

Relative's Name	Relation to you	Type of cancer	Date of cancer
	Mother	Ovarian	?? ??
	Father	Lung	?? ??

Relative's Name	Relation to you	Type of cancer	Date of cancer

8. Limiting this question to blood relatives, to the best of your knowledge, please indicate whether your *parents, siblings, children, grandparents, aunts, uncles, or first cousins* have ever been diagnosed with any genetic mutations, including but not limited to BRCA1 or BRCA2 mutations?

Choose Yes/No: No

If yes, please identify each such relative's relation to you:

_____

HEALTH CARE PROVIDERS AND PHARMACIES

9. Limiting your answer to primary care, gynecology and oncology healthcare providers, identify each doctor or other health care provider who you have seen for medical care and treatment from the ten (10) years prior to your ovarian cancer diagnosis to the present. In particular, please use your best efforts to list all of the primary care providers during this period.

Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Approximate Years of Visits
			to
			to
			to
			to
			to

Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Approximate Years of Visits
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Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Approximate Years of Visits
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Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Approximate Years of Visits
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Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Approximate Years of Visits
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Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Approximate Years of Visits
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Doctor or Healthcare Provider's Name	Doctor or Healthcare Provider's Specialty	Address	Approximate Years of Visits
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10. If any of your healthcare providers who you have seen in relation to treatment and care of **ovarian cancer or any other form of cancer** were not identified previously, please identify for each such provider:

Name and Specialty	Address	Approximate Years of Treatment	Reason for Treatment
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		to	

Name and Specialty	Address	Approximate Years of Treatment	Reason for Treatment
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		to	
		to	
		to	
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		to	

Name and Specialty	Address	Approximate Years of Treatment	Reason for Treatment
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		to	
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		to	
		to	

11. Limiting your response to visits for issues related to cancer and to gynecologic issues other than pregnancy, identify each hospital, clinic, or health care facility where you were hospitalized (inpatient, out-patient, or emergency room visit) from the (10) years prior to your ovarian cancer diagnosis to the present:

Name	Address	Admission Date(s)	Reason for Admission Approx. Years of Visits

Name	Address	Admission Date(s)	Reason for Admission Approx. Years of Visits

Name	Address	Admission Date(s)	Reason for Admission Approx. Years of Visits

Name	Address	Admission Date(s)	Reason for Admission Approx. Years of Visits

12. To the best of your recollection, identify each pharmacy that has regularly dispensed medication to you from the ten (10) years prior to your ovarian cancer diagnosis to the present:

Name of Pharmacy	Address of Pharmacy	Approx. Years You Used Pharmacy
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		to
		to
		to
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		to
		to
		to

Name of Pharmacy	Address of Pharmacy	Approx. Years You Used Pharmacy
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Name of Pharmacy	Address of Pharmacy	Approx. Years You Used Pharmacy
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Name of Pharmacy	Address of Pharmacy	Approx. Years You Used Pharmacy
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13. Has any health care provider told you the cause(s) of your ovarian cancer?

Choose Yes/No: No

If yes, please identify the name of said health care provider, the approximate date on which he/she did so, and the substance of the conversation:

Healthcare Provider's Name	Approximate Date of Conversation	Substance of Conversation

Healthcare Provider's Name	Approximate Date of Conversation	Substance of Conversation

14. Have you had any communications with your health care providers, orally or in writing, about whether your condition is related to your use of Johnson's Baby Powder and/or Shower to Shower?

Choose Yes/No: No

If yes, please identify the name and approximate date of communication with said health care provider:

Healthcare Provider's Name	Approximate Date of Conversation

TALCUM POWDER PRODUCT USE

16. Have you ever used Johnson's Baby Powder? Choose Yes/No: Yes

If yes, identify:

a) Did you apply the product to your genital area? Choose Yes/No: Yes

b) Approximate year of first use: 1970

c) Approximate year of last use: 2005

d) Frequency of use during these dates:
Undetermined

17. Have you ever used Johnson & Johnson Shower to Shower? Choose Yes/No: Yes

If yes, identify:

a) Did you apply the product to your genital area? Choose Yes/No: Yes

b) Approximate year of first use: _____

c) Approximate year of last use: _____

d) Frequency of use during these dates:
Undetermined

18. Have you ever used any other cosmetic powder product(s) in your genital area?

Choose Yes/No: _____

If yes, identify:

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

a) Name of product(s): _____

b) Approximate year of first use: _____

c) Approximate year of last use: _____

MEDICAL BACKGROUND OF BODY POWDER USER

19. What is your height? 5 ft. 5 inches.

20. Highest weight during the five years prior to your ovarian cancer diagnosis: _____ lbs.

Lowest weight during the five years prior to your ovarian cancer diagnosis: 112 lbs.

21. Smoking History:

a. Do you currently smoke cigarettes? Choose Yes/No: _____

-- If yes, for how long have you smoked? _____

-- If yes, how many cigarettes/packs per day do you smoke? _____

b. Have you ever smoked cigarettes in the past? Choose Yes/No: Yes

-- If yes, when did you begin such smoking? _____

-- When did you stop smoking? _____

-- How many cigarettes/packs per day did you smoke until you stopped?

_____

22. Menstrual History:

a. Age at first menstrual period: _____

b. Age at last menstrual period: _____

c. Average length of period: _____

23. Pregnancies:

Number of pregnancies? 4

Years of pregnancy(s): _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

Number of births? 4

24. **Employment History:**

Are you currently employed? Choose Yes/No: _____
If yes, please identify your current employer and position:

25. **Education:**

Highest Educational Degree	Educational Institution

DOCUMENT DEMANDS

Documents in your possession, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession, please indicate which documents you have and attach a copy of them to this Plaintiff Profile Form):

1. All documents relating to plaintiff's purchase(s) or acquisition(s) of Johnson's Baby Powder or Shower to Shower, including but not limited to, store receipts, credit card receipts, containers, labels, or other records of purchase or acquisition.

2. All medical records, reports, and/or documents from any hospital, physician, or other health care provider who treated plaintiff for ovarian cancer or any gynecologic disease, condition or symptom alleged in the Complaint and/or PPF.

3. If applicable, decedent-user's death certificate and copies of letters testamentary or letters of administration confirming standing of the named plaintiff.

4. A copy of all pathology reports related to plaintiff's/decedent's diagnosis or recurrence of ovarian cancer.

5. A copy of all reports reflecting any genetic testing undertaken on plaintiff/decedent.

DECLARATION

I declare under penalty of perjury that all of the information provided in connection with this Short Form Plaintiff Profile Form is true and correct to the best of my knowledge, information, and belief formed after due diligence and reasonable inquiry. I acknowledge that I have an obligation to supplement the above responses if I become aware of additional responsive information, or if I learn that they are in some material respects incomplete or incorrect.

Date: _____

_____
Signature of Plaintiff

_____
Print Name of Signing Plaintiff